

**DOD MEDICAL EXAMINATION REVIEW BOARD (DODMERB)  
REPORT OF MEDICAL HISTORY**

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved  
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**PRIVACY ACT STATEMENT**

**AUTHORITY:** Title 10, USC 133, 3012, 5031, 8013, and Executive Order 9397.

**PRINCIPAL PURPOSE:** To determine medical acceptability or update a medical file as part of the application process to a United States Service Academy, Reserve Officer Training Corps (ROTC) Scholarship Program, or the Uniformed Services University of the Health Sciences (USUHS).

**ROUTINE USES:** This information may be disclosed to the Coast Guard Academy and Merchant Marine Academy for applications to their Academies.

**DISCLOSURE:** Voluntary; however, failure to furnish the requested information will impede the selection process and hamper your candidacy. Use of the Social Security Number (SSN) is used for positive identification of records.

1. NAME (Last, First, Middle Initial)	2. SOCIAL SECURITY NUMBER	3. TELEPHONE NO. (Include area code)
4. PURPOSE OF EXAMINATION	5. EXAMINATION FACILITY OR EXAMINER AND ADDRESS (Include ZIP Code)	6. DATE OF EXAMINATION (YYYYMMDD)

**SECTION I**

Mark each item "Yes" or "No". Every question must be answered. Every "Yes" must be explained in the REMARKS section. Mark and explain each item to the best of your ability. Be perfectly honest! Your medical records may be requested to clarify your medical history.

YES	NO	THE FOLLOWING:	YES	NO	DO YOU	9a. If you wear contact lenses, how many days have they been removed prior to this examination?		
			Marijuana	Alcohol (Amount, frequency, treatment, if any)			8. Wear glasses	Less than 3
		Amphetamines			9. Wear contact lenses or corneal eye retainers (If Yes, complete 9a.)	Type lens: Hard Soft		
		Barbiturates						
		Cocaine			10. Have your vision corrected by orthokeratology (corneal molding) or keratorefractive surgery of any type (e.g., RK, PRK)			
		Narcotic Drugs						
YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO		YES	NO	
		11. Eye trouble (exclude glasses, contact lenses)			40. Gallbladder trouble or gallstones			66. Sleepwalking episodes after age 12
		12. Have fluctuating vision or double vision			41. Hepatitis (yellow jaundice)			67. Easily fatigued
		13. Have any allergies			42. Hemorrhoids or rectal disease			68. Motion sickness (car, train, sea, or air)
		14. Take any medications regularly			43. Black or bloody stools			69. X-ray or other radiation therapy
		15. Stutter or stammer			44. Frequent or painful urination			70. Sensitivity to chemicals, dust, sunlight, etc.
		16. Frequent, severe, or migraine headaches			45. Bed wetting after age 12			71. Learning disabilities or speech problems
		17. Fainting or dizzy spells			46. Blood, protein, or sugar in urine	YES	NO	HAVE YOU EVER
		18. Periods of unconsciousness			47. History of diabetes			72. Been refused employment or been unable to hold a job or stay in school because of:
		19. Head injury or skull fracture			48. Kidney stone			a. Inability to perform certain movements? b. Inability to assume certain positions? c. Other medical reasons?
		20. Epilepsy, seizures or convulsions			49. Hernia or rupture			73. Been rejected for or discharged from military service because of physical, mental or other reasons?
		21. Loss of memory (amnesia)			50. Any bone or joint problem, injuries, surgery or medical treatment			74. Been denied or rated up for life insurance?
		22. Depression, anxiety, excessive worry, or nervousness			51. Steel pins, plates, or staples in any bones			75. Received or applied for pension or compensation for existing disability?
		23. Any mental condition or illness			52. Wear a bone or joint brace or support			76. Had or been advised to have, any surgical operations?
		24. Frequent trouble sleeping			53. Back pain or trouble			77. Consulted, or been treated by clinics, hospitals, physicians, healers, or other practitioners for other than minor illnesses?
		25. Hearing loss			54. Paralysis or weakness			78. Had any injury or illness other than those already noted?
		26. Ear, nose, or throat trouble			55. Foot trouble			79. Been treated for a female disorder, painful periods, or cramps
		27. Sinusitis or sinus trouble			56. Rheumatic fever			80. Had a change in menstrual pattern
		28. Hay fever or allergic rhinitis			57. Tuberculosis or positive TB test			81. Are you now pregnant?
		29. Severe tooth or gum trouble			58. Sexually transmitted disease (syphilis, gonorrhea, herpes)			82. Date of last menstrual period (YYYYMMDD)
		30. Thyroid trouble			59. Skin conditions such as acne, psoriasis, hand or foot rashes, eczema, or dry skin			
		31. Chronic cough or lung disease			60. Adverse reaction to vaccines, drugs, medicines, foods, insect bites or stings	YES	NO	FEMALES ONLY (Complete Items 79 - 82)
		32. Asthma or wheezing			61. Eating disorder			79. Been treated for a female disorder, painful periods, or cramps
		33. Unusual shortness of breath			62. Recent gain or loss of weight			80. Had a change in menstrual pattern
		34. Pain or pressure in chest			63. Excessive bleeding or easy bruising			81. Are you now pregnant?
		35. Palpitation or pounding heart			64. Tumor, growth, cyst, or cancer			82. Date of last menstrual period (YYYYMMDD)
		36. Heart trouble or heart murmur			65. Considered or attempted suicide			
		37. High blood pressure						
		38. Coughed up or vomited blood						
		39. Stomach, liver, or intestinal trouble						

**SECTION II**

**83. REMARKS.** (Every "yes" response in items 7 through 81 must be explained in the space provided. Give specific dates and details including names of physicians and hospitals or clinics and the current status of the condition. Continue on a separate sheet and attach to this form if additional space is needed.)

**84. CERTIFICATION.** I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the physicians, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE	DATE SIGNED (YYYYMMDD)
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**NOTE: HAND TO THE PHYSICIAN OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."**

**85. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA** (Examiner shall comment on all "Yes" and blank answers (indicating the item number before each comment). Develop by interview any additional medical history deemed important, and record significant findings here. If additional space is needed, continue on a separate sheet and attach to this form.)

<b>86. PHYSICIAN OR EXAMINER</b>		
TYPED OR PRINTED NAME	SIGNATURE	DATE SIGNED (YYYYMMDD)
		<b>87. NUMBER OF ATTACHED SHEETS</b>